

literature. In 4250 autopsy records he found 35 instances of tuberculosis of the epididymis, the most common lesion of the genital tract to be observed clinically, in which a microscopical examination as well as a gross description of the condition of the prostate and vesicles is recorded. He found 86 clinical cases of tuberculous epididymitis. A consideration of the literature, both postmortem and clinical, shows that tuberculosis of the genital tract in the male, is most common in the epididymis, and from the epididymis the disease extends along the vas, either by continuity or lymphatics to the vesicles and prostate. The postmortem and clinical findings show that the great majority of cases of genital tuberculosis have active tuberculosis elsewhere in the body, the infection in the genito-urinary tuberculosis being a secondary one. It must be considered that the majority of cases of tuberculous epididymitis have tuberculosis of the vesicles and prostate on the corresponding side, whether the condition can be demonstrated by physical examination or not. Cases of genital tuberculosis often have associated tuberculosis of the bladder and kidney, and a cystoscopic examination with catheterization of the ureter should be a routine procedure, in each case, before the possibility of such associated infection can be eliminated. In the opinion of Cunningham, the best treatment for the local condition, in most instances, is to remove the scrotal focus by epididymectomy or castration, and this should be followed by injecting the vas with a dram of crude carbolic acid, with the hope of eradicating the disease from the genital tract. The destruction of the local focus is but the first step in the process of immunizing the patient against fresh outbreaks of the disease; and the hygiene and tuberculin should be made use of indefinitely, as they serve further to aid in a rational way, the immunizing power of the body against remaining lesions.

Perforation in Typhoid Fever.—EDDY (*Surg., Gynec. and Obst.*, 1916, xxxiii, 451), from a report of one case and an extensive study of the literature, concludes that: While perforation varies greatly in different epidemics, about 12 per cent. of the total death-rate is due to this complication. Perforation occurs in about 3 per cent. of all cases treated. It is relatively infrequent in children. Statistics show that 80 per cent. of total perforations occur in the lower ileum. The majority of cases perforate during the second and third week. Diarrhea is an important factor in its production. Acute abdominal pain in the course of typhoid should always be taken seriously. The sudden rise of blood-pressure is positive evidence of perforation, while an unchanged pressure is not of negative value. The importance of a careful study of the blood cannot be overestimated. The welfare of the patient depends upon our ability to differentiate between the symptoms of perforation and those of the resulting peritonitis. The treatment of perforation is surgical, and the death-rate is in inverse ratio to the length of time allowed to elapse before operation. Opiates are indicated as soon as perforation has taken place and should be continued until the peritonitis has become well localized.

The Treatment of Fractures by Nail Extension.—DYAS (*Surg., Gynec. and Obst.*, 1916, xxxiii, 478), on the basis of five cases treated by this method and a study of the literature, says that Steimann's nail exten-

sion in the treatment of fractures is less dangerous than the radical open operation. It enables the surgeon to exert the maximum amount of traction while using the minimum area for the attachment of the traction apparatus. It will bring about a reduction of the deformity in old cases where other methods fail. The technic is not difficult and can be mastered by anyone. Therefore the method is practical and can be used by the entire profession. It gives access to wounds in compound fractures, permits of infrequent dressings, and does away with unclean, infected fixation apparatus. The apparent brutality of the procedure is not real as the patients suffer no more by this traction than by any other method. The danger of infection is less than the danger of an open, radical operation. Hemorrhage may occur but can always be readily controlled by enlarging the incision and tying off the bleeding point.

THERAPEUTICS

UNDER THE CHARGE OF

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Splenectomy in Pernicious Anemia.—LEE, MINOT and VINCENT (*Jour. Am. Med. Assn.*, 1916, lxvii, 719) give their findings regarding the mode of action of splenectomy as a therapeutic procedure—particularly with regard to its effect in stimulating the bone marrow to produce new blood. They believe that splenectomy in pernicious anemia has in nowise a specific stimulating effect on any one portion or any one function of the bone marrow. It apparently acts grossly on all portions, though the effects are seen at different periods of time in relation to the operation. They attribute the temporary improvement in pernicious anemia after splenectomy to two factors: (1) an associated diminution in the blood destruction; and (2) the associated increase in activity of the bone marrow. They do not attempt to explain the precise mechanism by which splenectomy brings about an increased activity of the marrow. Certain stimulating effects after splenectomy are seen almost immediately, as in the case of the increase in the polymorphonuclear leukocytes. The increase in the platelets tends to occur somewhat later, and the main increase of the reticulated cells, when it occurs, seems to be inaugurated still later. This effect on the part of the bone marrow which forms red cells is much more difficult to bring about and also is slower. Splenectomy seems to result in the greatest stimulation of the bone marrow of any known therapeutic measure. It acts on the whole bone marrow and not only on the portion that forms red cells. However, splenectomy does not alter the essential course of the disease. While more constant stimulating effects are seen after splenectomy, yet they can roughly parallel